

CONFIDENTIAL REGISTRATION

Date: _____

Last Name: _____ First Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____ E-mail Address: _____

Emergency Contact: _____ Emergency Phone: _____

Employer Name : _____

Address: _____

Date of Birth: _____ S.S.#: _____

Gender: M F Marital Status: _____ Referred By: _____

Is condition related to: Illness Employment Auto Other _____ N/A

Date of Accident (if applicable): _____

Insurance Company Name: _____

Address: _____

Phone #: _____ Group#: _____ I.D.#: _____

Name of Insured: _____ Relationship to Insured: _____

Does your insurance company require a referral from your primary physician? _____

Name and phone number of primary care physician: _____

Do you have secondary insurance coverage? _____ Name of Company: _____

Spouse's Name: _____ Birthdate: _____

PATIENT AGREEMENT

I, the undersigned have insurance coverage, with _____, and assigned directly to Dr. Coyne all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I realize that insurance assignment is a courtesy extended by the doctors and that I am ultimately responsible for payment of all services rendered if the insurance company denies payment to the office.

Signature: _____ Date: _____

DR. ELLEN COYNE, Chiropractor 164 West 79 Street, New York, NY 10024 (212) 875 - 9780

Patient Health Questionnaire - PHQ

ACN Group, Inc. Form PHQ-202

ACN Group, Inc. Use Only rev 3/27/2003

Patient Name _____ Date _____

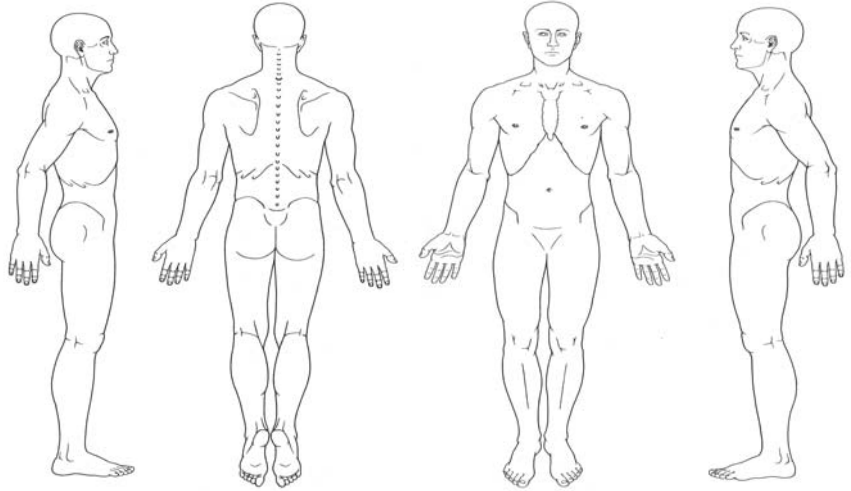
1. Describe your symptoms

a. When did your symptoms start? _____

b. How did your symptoms begin? _____

2. How often do you experience your symptoms? Indicate where you have pain or other symptoms

- ① Constantly (76-100% of the day)
- ② Frequently (51-75% of the day)
- ③ Occasionally (26-50% of the day)
- ④ Intermittently (0-25% of the day)



3. What describes the nature of your symptoms?

- ① Sharp
- ② Dull ache
- ③ Numb
- ④ Shooting
- ⑤ Burning
- ⑥ Tingling

4. How are your symptoms changing?

- ① Getting Better
- ② Not Changing
- ③ Getting Worse

5. During the past 4 weeks:

a. Indicate the average intensity of your symptoms

None ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨ ⑩ Unbearable

b. How much has pain interfered with your normal work (including both work outside the home, and housework)

① Not at all ② A little bit ③ Moderately ④ Quite a bit ⑤ Extremely

6. During the past 4 weeks how much of the time has your condition interfered with your social activities?

(like visiting with friends, relatives, etc)

① All of the time ② Most of the time ③ Some of the time ④ A little of the time ⑤ None of the time

7. In general would you say your overall health right now is...

① Excellent ② Very Good ③ Good ④ Fair ⑤ Poor

8. Who have you seen for your symptoms?

- ① No One
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

a. What treatment did you receive and when? _____

b. What tests have you had for your symptoms and when were they performed?

- ① Xrays date: _____
- ② MRI date: _____
- ③ CT Scan date: _____
- ④ Other date: _____

9. Have you had similar symptoms in the past?

- ① Yes
- ② No

a. If you have received treatment in the past for the same or similar symptoms, who did you see?

- ① This Office
- ② Other Chiropractor
- ③ Medical Doctor
- ④ Physical Therapist
- ⑤ Other

10. What is your occupation?

- ① Professional/Executive
- ② White Collar/Secretarial
- ③ Tradesperson
- ④ Laborer
- ⑤ Homemaker
- ⑥ FT Student
- ⑦ Retired
- ⑧ Other

a. If you are not retired, a homemaker, or a student, what is your current work status?

- ① Full-time
- ② Part-time
- ③ Self-employed
- ④ Unemployed
- ⑤ Off work
- ⑥ Other

Patient Signature _____ Date _____

Patient Health Questionnaire- page 2

Patient Name _____

What type of regular exercise do you perform? (1) None (2) Light (3) Moderate (4) Strenuous

What is your height and weight? Height ____ft____inches Weight ____lbs.

For each of the condition listed below, place a check in the Past column if you have had the condition in the past. If you presently have a condition listed below, place a check in the Present column.

Past	Present		Past	Present		Past	Present	
<input type="radio"/>	<input type="radio"/>	HEADACHE	<input type="radio"/>	<input type="radio"/>	HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	DIABETES
<input type="radio"/>	<input type="radio"/>	NECK PAIN	<input type="radio"/>	<input type="radio"/>	HEART ATTACK	<input type="radio"/>	<input type="radio"/>	EXCESSIVE THRIST
<input type="radio"/>	<input type="radio"/>	UPPER BACK PAIN	<input type="radio"/>	<input type="radio"/>	CHEST PAINS	<input type="radio"/>	<input type="radio"/>	FREQUENT URINATION
<input type="radio"/>	<input type="radio"/>	MID BACK PAIN	<input type="radio"/>	<input type="radio"/>	STROKE			
<input type="radio"/>	<input type="radio"/>	LOW BACK PAIN	<input type="radio"/>	<input type="radio"/>	ANGINA	<input type="radio"/>	<input type="radio"/>	SMOKING
			<input type="radio"/>	<input type="radio"/>	KIDNEY DISORDER	<input type="radio"/>	<input type="radio"/>	DRUG/ALCOHOL
<input type="radio"/>	<input type="radio"/>	SHOULDER PAIN	<input type="radio"/>	<input type="radio"/>	BLADDER INFECTION			DEPENDENCE
<input type="radio"/>	<input type="radio"/>	ELBOW/UPPER ARM PAIN	<input type="radio"/>	<input type="radio"/>	PAINFUL URINATION	<input type="radio"/>	<input type="radio"/>	ALLERGIES
<input type="radio"/>	<input type="radio"/>	WRIST PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF BLADDER CONTROL	<input type="radio"/>	<input type="radio"/>	DEPRESSION
<input type="radio"/>	<input type="radio"/>	HAND PAIN	<input type="radio"/>	<input type="radio"/>	PROSTATE PROBLEMS	<input type="radio"/>	<input type="radio"/>	SYSTEMIC LUPUS
						<input type="radio"/>	<input type="radio"/>	EPILEPSY
<input type="radio"/>	<input type="radio"/>	HIP/UPPER LEG PAIN	<input type="radio"/>	<input type="radio"/>	ABNORMAL WEIGHT GAIN/LOSS	<input type="radio"/>	<input type="radio"/>	DERMATITIS/
<input type="radio"/>	<input type="radio"/>	KNEE/LOWER LEG PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF APPETITE			ECZEMA/RASH
<input type="radio"/>	<input type="radio"/>	ANKLE/FOOT PAIN	<input type="radio"/>	<input type="radio"/>	ABDOMINAL PAIN	<input type="radio"/>	<input type="radio"/>	HIV/AIDS
<input type="radio"/>	<input type="radio"/>	JAW PAIN	<input type="radio"/>	<input type="radio"/>	LOSS OF APPETITE			
			<input type="radio"/>	<input type="radio"/>	ABDOMINAL PAIN			FEMALES ONLY
<input type="radio"/>	<input type="radio"/>	JOINT SWELLING/STIFFNESS	<input type="radio"/>	<input type="radio"/>	HEPITITIS	<input type="radio"/>	<input type="radio"/>	BIRTH CONTROL PILLS
<input type="radio"/>	<input type="radio"/>	ARTHRITIS	<input type="radio"/>	<input type="radio"/>	LIVER/GALL BLADDER DISORDER	<input type="radio"/>	<input type="radio"/>	HORMONAL
<input type="radio"/>	<input type="radio"/>	RHEUMATOID ARTHRITIS	<input type="radio"/>	<input type="radio"/>	CANCER			REPLACEMENT
			<input type="radio"/>	<input type="radio"/>	TUMOR	<input type="radio"/>	<input type="radio"/>	PREGNANCY
<input type="radio"/>	<input type="radio"/>	GENERAL FATIGUE	<input type="radio"/>	<input type="radio"/>	ASTHMA			OTHER HEALTH ISSUES:
<input type="radio"/>	<input type="radio"/>	MUSCULAR INCOORDINATION	<input type="radio"/>	<input type="radio"/>	CHRONIC SINUSITIS	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	VISUAL DISTURBANCES				<input type="radio"/>	<input type="radio"/>	
<input type="radio"/>	<input type="radio"/>	DIZZINESS				<input type="radio"/>	<input type="radio"/>	

INDICATE IF AN IMMEDIATE FAMILY MEMBER HAS HAD ANY OF THE FOLLOWING:

Rheumatoid Arthritis Heart Problem Diabetes Cancer Lupus _____

List all prescription and over-the-counter medications, and nutritional/herbal supplements you are taking:

List all the surgical procedures you have had and times you have been hospitalized:

Patient Signature _____ Date _____

Provider's Additional Comments

Doctor's Signature _____ Date _____

Workers' Compensation Questionnaire

A. Patient's Information

1. Name: _____ 2. Social Security #: _____
3. Home phone #: (____) _____
4. WCB Case # (if known) _____ 5. Carrier Case # (if known) _____
6. Mailing address: _____
7. Date of injury/onset of illness: ____/____/____ 8. Date of birth: ____/____/____
9. Gender: Male Female
10. On the date of injury/illness what was the patient's job title or description: _____
11. On the date of injury/illness what were the patient's usual work activities: _____

B. Employer Information

1. Employer when injury occurred _____ 2. Phone #: (____) _____
Company/Agency Name
3. Employer Address: _____
Number and Street City State Zip Code

C. Billing Information

1. Employer's insurance company: _____
2. Insurance company's address: _____
Number and Street City State Zip Code

D. History

1. Where and how did the injury/illness happen:

2. Did another health provider treat this injury/illness including hospitalization and/or surgery?
O Yes O No If yes, give details: _____

E. Symptoms

- Subjective complaints: *Check all that apply and identify specific affected body part(s).*
- O Numbness/Tingling _____ O Swelling _____
O Pain _____ O Weakness _____
O Stiffness _____ O Other (specify) _____

F. Work Status

1. Have you missed work because of the injury/illness? O Yes O No
If yes, date you first missed work: ____/____/____
2. Have you returned to work? O Yes O No
If yes, date you returned: ____/____/____
Are your work activities restricted as a result of accident? O Yes O No
If yes, give details: _____

G. Attorney Information:

1. Have you retained an attorney for this case? O Yes O No
If so, name and address: _____

Patient Signature: _____ **Date:** _____